SENATE BILL 742
By Kelsey

HOUSE BILL 1116

By Sexton J

AN ACT to amend Tennessee Code Annotated, Title 56 and Title 71, relative to healthcare coverage.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF TENNESSEE:

SECTION 1. The commissioner of finance and administration is directed to submit to the federal centers for medicare and medicaid services a waiver amendment to the existing TennCare II waiver or to submit a new waiver in order to authorize use of personal health accounts in accordance with this act within one hundred twenty (120) days of the effective date of this act.

SECTION 2.

(a) In accordance with terms of an appropriate federal waiver for providing medical assistance in this state, each enrollee for medical assistance shall receive a personal health account (PHA) for the purpose of paying for a portion of the enrollee's healthcare expenses and exercising the enrollee's market power of a consumer of goods and services.

(b) The PHA shall be funded on a quarterly basis with an actuarially determined amount that is substantially based on current fee-for-service average expenses after an appropriate risk adjustment. The risk adjustment shall reflect eligibility categories, age, gender, and health status. The PHA shall be available on an individual basis.

(c) Each qualifying enrollee shall use the PHA to purchase a benefit coverage plan from an array of options approved by the bureau of TennCare. The coverage options will range from a safety net of limited benefits to full-service benefit plans. The range of options shall provide a broad continuum of consumer flexibility, including, but

not limited to, managed care organizations, self-directed plans, and medical home networks. Plans offered as options shall directly compete for the enrollee's business.

(d) An enrollee may choose to use the full amount of the PHA to purchase comprehensive or partial coverage plans. If the enrollee selects a plan that has rates that are lower than the total amount of the PHA, then the enrollee may retain any balance of the PHA to spend on healthcare related items. A PHA may not be used to purchase food, clothing, or shelter. Unused balances shall roll forward to the next quarter.

(e) When an enrollee is no longer eligible for medical assistance under the Medical Assistance Act of 1968, compiled in title 71, chapter 5, part 1, a portion of the unused balance of a PHA may be used for healthcare expenses or to purchase health insurance. Unused funds shall revert to the state after twelve (12) months. Unused funds in a PHA revert to the state on the death of an enrollee.

SECTION 3. Tennessee Code Annotated, Title 56, Chapter 7, is amended by adding the following as a new, appropriately designated part:

56-7-3501. This part shall be known and may be cited as the "Healthcare Choice Act."

56-7-3502. For the purposes of this part:

(1) "Commissioner" means the commissioner of commerce and insurance;

(2) "Foreign health insurer" means a foreign individual health insurer or a foreign small employer health insurer;

(3) "Foreign individual health insurer" means a person domiciled in a state other than Tennessee who holds a valid certificate of authority to market individual health insurance plans in the state of its domicile;

(4) "Foreign small employer health insurer" means a person domiciled in a state other than Tennessee who holds a valid certificate of authority to market small employer health insurance plans in the state of its domicile;

(5) “Individual health benefits plan” means a benefits plan for individuals and their dependents that pays or provides for hospital and medical expense benefits for covered services;

(6) “Small employer” has the same meaning as the term is defined in § 56-7-2203; and

(7) “Small employer health benefits plan” means a group benefits plan for individuals and their dependents that pays or provides for covered services, offered by a small employer.

56-7-3503.

(a) Notwithstanding any other law to the contrary, a foreign individual health insurer may offer and provide individual health benefits plans to residents in this state, if that insurer:

(1) Offers the same individual health benefits plans in its domiciliary state and is in compliance with all applicable laws, regulations, and other requirements of its domiciliary state;

(2) Obtains a certificate of authority to do business as a foreign health insurer in this state, pursuant to § 56-7-3504; and

(3) Participates, on a nondiscriminatory basis, in the Tennessee life and health insurance guaranty association created by § 56-12-205.

(b) Notwithstanding any other law to the contrary, a foreign small employment health insurer may offer and provide small employer health benefits plans to employers in this state, if that insurer:

(1) Offers the same small employer health benefits plans in its domiciliary state and is in compliance with all applicable laws, regulations, and other requirements of its domiciliary state;

(2) Obtains a certificate of authority to do business as a foreign health insurer in this state, pursuant to § 56-7-3504; and

(3) Participates, on a nondiscriminatory basis, in the Tennessee life and health insurance guaranty association created by § 56-12-205.

56-7-3504.

(a) A foreign health insurer may apply for a certificate of authority to do business as a foreign health insurer in this state using a form prescribed by the commissioner. The commissioner shall issue a certificate of authority to the foreign health insurer if the insurer submits a complete application and application fee; provided, however, that no certificate shall be issued if the commissioner determines that the insurer:

(1) Will not provide health insurance services in compliance with this part;

(2) Does not meet minimum capital, surplus, and reserve requirements established by the commissioner;

(3) Is not subject to measures of regulatory oversight that are equal to or exceed those of this state; and

(4) Has not adopted procedures to ensure compliance with all federal laws and the laws of this state governing the confidentiality of its records with respect to providers and covered persons, including, but not limited to, the Patient's Privacy Protection Act, compiled in title 68, chapter 11, part 15.

(b) A certificate of authority issued pursuant to this section shall be valid for two (2) years from the date of issuance by the commissioner.

(c) The commissioner shall establish:

(1) Procedures for a foreign health insurer to renew a certificate of authority consistent with this part; and

(2) Certificate of authority application and renewal fees to offset the cost of administrative and enforcement provisions of this part.

56-7-3505.

(a) Each individual health benefits plan provided by a foreign individual health insurer to a resident of this state, and each application for the plan, shall disclose the following information in plain language:

(1) The differences between the coverage of certain healthcare services and benefits by the individual health benefits plan issued by the foreign health insurer and the coverage of such services and benefits mandated by Tennessee law using at least fourteen (14) point bold type; and

(2) An explanation of which state's laws govern the issuance of, and requirements under, the individual health benefits plan offered under this part.

(b) Each group health benefits plan provided by a foreign small employer health insurer to a small employer in this state, and each application for the plan, shall disclose the following information in plain language:

(1) The differences between the small employer health benefits plan issued by the foreign health insurer and plans approved pursuant to this title using at least fourteen (14) point bold type to describe the differences that relate to underwriting standards, premium ratings, preexisting conditions, renewability, portability, and cancellation; and

(2) An explanation of which state's laws govern the issuance of, and requirements under, the small employer health benefits plan offered under this part.

56-7-3506.

(a) The commissioner may deny, revoke, or suspend, after notice and opportunity to be heard as provided in the Uniform Administrative Procedures Act compiled in title 4, chapter 5, a certificate of authority issued to a foreign health insurer pursuant to this part for a violation of this part, including any finding by the commissioner that a foreign health insurer is no longer in compliance with any of the conditions for issuance of a certificate of authority set forth in § 56-7-3504(a), or the rules adopted pursuant to this part.

(b) Any foreign health insurer who violates this part shall be subject to § 56-2-305 only with respect to violations of this part.

(c) The commissioner shall establish grievance and independent claims review procedures with respect to claims by a healthcare provider or a covered person with which a foreign health insurer shall comply as a condition of issuing policies in this state. The procedures shall be consistent with those set forth in state law for domestic insurers, including §§ 56-7-109 and 56-7-110. These procedures and standards shall be applied on a nondiscriminatory basis so as not to place greater responsibilities on foreign health insurers than the responsibilities placed on other health insurers doing business in this state.

56-7-3507. A foreign health insurer offering individual or small employer health benefits plans pursuant to this part shall comply with:

(1) The Tennessee Unfair Trade Practices and Unfair Claims Settlement Act of 2009, compiled in chapter 8, part 1, of this title;

(2) Chapter 4, part 2, of this title relative to premium taxes, if applicable;

(3) Applicable provisions of the Tennessee life and health insurance guaranty association, created by § 56-12-205; and

(4) The capital, surplus, and reserve requirements established by the commissioner.

56-7-3508. The commissioner shall promulgate rules to effectuate the provisions of this part in accordance with the Uniform Administrative Procedures Act, compiled in title 4, chapter 5; provided, however, that except as provided in § 56-7-3507, no rule shall:

(1) Directly or indirectly require a foreign health insurer to, directly or indirectly, modify coverage or benefit requirements, or restrict underwriting requirements or premium ratings, in any way that conflicts with the insurer's domiciliary state's law or regulations;

(2) Provide for regulatory requirements that are more stringent than those applicable to domestic carriers that are authorized by the commissioner to provide health benefit plans in this state; or

(3) Require any individual health benefits plan or small employer health benefits plan issued by the foreign health insurer to be countersigned by an insurance agent or broker residing in this state.

SECTION 4. The commissioner of finance and administration is authorized to promulgate rules to effectuate the purposes of this act. All such rules shall be promulgated in accordance with the Uniform Administrative Procedures Act, compiled in title 4, chapter 5.

SECTION 5. This act shall take effect July 1, 2015, the public welfare requiring it.